

REQUEST FOR CONSULTATION

FAX TO: 920.499.9636

Requesting Doctor: _____ Date: _____

Patient: _____ DOB: _____

Consultation Appointment Date: _____ Time: _____

Referred to: Tyson K. Schwiesow Kurt A. Schwiesow
 Matthew J. Thompson Kunal S. Patel

Reason for Consultation:

_____ **Cataract** _____ **Glaucoma** _____ **Cornea**

_____ **Other:** _____

- Patient requests to co-manage post-operative care
- History of elevated IOP/glaucoma
- History of significant dry eye
- History of retinal disease

Ophthalmic History:

Ophthalmic Medication:

Tonometry: OD _____ mm Hg
 OS _____ mm Hg

Refraction: OD _____ + _____ x _____ 20/_____
 OS _____ + _____ x _____ 20/_____

Slit Lamp Exam:

Fundus:

Comments: _____

Signature

Date